Mass Shooting/ No-Notice Incident After-Action Interview Guide: Medical Resource Requirements

This list of questions was used to help ASPR TRACIE staff interview various Las Vegas hospital personnel to collect and synthesize information from their mass shooting response. Results were used to develop a suite of No-Notice Incident Tip Sheets.

Incident Command System (ICS)
1. What worked well?
2. What did not?
3. Command center activation issues?
4. Staff call back / notification issues?
5. Coordination / information flow with emergency medical systems (EMS)
6. Coordination / information flow with law enforcement (LE)
7. Coordination/information flow inside the facility with administrative and other departments
8. Coordination / information flow with other hospitals
9. Public relations / external communications

Emergency Department (ED)
1. What worked well?
2. What did not?
3. Number of usual beds?
4. Number and location of surge beds?
5. Process for making space in the ED (clearing current patients)
6. Mode of arrival?
7. Triage process / system?
   a. Did the triage process correctly classify patients?
   b. Who cared for the minimally injured patients?
8. Rapid registration and tracking process?
9. Unidentified patient process?
10. Number of initially unidentified patients?
11. Charting expectations? (Temporary vs. usual charting? Other changes to EHR?)
12. Sources of carts / WC?
13. Access controls / security issues?
14. Patient flow issues?
15. Disaster staffing – source and issues?
16. Total patients and distribution over time?

17. Total critical patients?
18. Number of deaths (pronounced DOA, ED, OR, inpatient)
    a. How were expectant patients managed?
    b. How was pastoral care delivered or not?
    c. Ways in which palliative care maintained?
19. Total intubations?
20. Total chest tubes placed?
21. Total thoracotomies (if any)?
22. Injury Severity Score (ISS) mean / median?
23. Crisis care decisions? (e.g., expectant triage, crisis use of staff/materials / rationing)
24. Supply issues? (including pediatric / specialty equipment)
25. Number of tourniquets used?
26. Types of tourniquets used?
27. Number of victims arriving with tourniquet placed?
28. Other issues / comments?
29. Interface with EMS
    a. Trip sheets/patient records
    b. Report outs / handoffs
    c. Equipment issues
    d. Access to ED
30. What happened to non-shooting patients already in the ED awaiting care/disposition?

Radiology
1. What worked well?
2. What did not?
3. Location and number of CT? Issues / bottlenecks?
4. ED ultrasound machines – number and use in incident?
5. Portable Xray number? Issues?
6. Number of studies first 6 hours CT?
7. Number of studies first 6h plain imaging?
8. How interpreted?
9. How communicated?
10. Other issues / comments?
11. Imaging in OR vs Imaging in ED—equipment and staff?

Blood Bank
1. What worked well?
2. What did not?
3. Packed red blood cells (PRBCs) used first 12h
4. Fresh frozen plasma (FFP) used first 12h
5. Transfusion issues? (tracking / administration/reactions)
6. Number of patients transfused?
7. Blood provider / resupply (and timeline) – is there a disaster protocol?
8. Blood bank staff working first 6h
9. Supply shortages?
10. O-neg shortages/O-pos shortages?
11. Volunteer donor issues at the hospital?
12. Other issues / comments?

Sterile Supply
1. What worked well?
2. What did not? (bottlenecks)
3. Any disaster carts / process?
4. Major procedure trays in stock?
5. Number of major trays used first 12h
6. Vascular trays in stock?
7. Number of vascular trays used first 12h
8. Amputation trays in stock?
9. Amputation trays used first 12h
10. Chest tube trays in stock
11. Turnover time – major tray
12. Other issues / comments/unanticipated needs

Surgery
1. What worked well?
2. What did not?
3. Any issues with room turn-over?
4. Number surgeries first 12h
5. Number of OR active in first 12h
6. Number of staff surgeons/surgical residents first 12h
7. Number of damage control surgeries performed
8. Number of anesthesiologists / CRNA used first 12h
9. Total laparotomies
10. Total neurosurgical cases
11. Total vascular cases
12. Total thoracic cases
13. Total orthopedic cases
14. Number external fixators used

15. Crisis care strategies? (triage of staff / resources or unusual resources used)
16. Other issues? (pre-induction, PACU?)
17. Consider looking at length of stay (LOS), wound infection, complication rates – this does not have to be solely through your facility's process but shared / pooled results from multiple facilities would be excellent.

Pharmacy
1. What worked well?
2. What did not?
3. Number of staff working first 12h
4. Any disaster cache / stocks policy?
5. Any shortages?
6. Issues with automatic dispensing systems?
7. Issues with controlled substances?
8. Total narcotics given first 24h?
9. Total doses IV antibiotics given first 24h?
10. Any issues with shortages during incident?
11. How were orders to the pharmacy triaged?
12. What processes were changed to meet surge demands?
13. Consider looking at whether there were any prescribing errors or administration errors.

Inpatient
1. What worked well?
2. What did not?
3. How were admits coordinated? (destination, etc.?)
4. Floor / step down admissions
5. Critical care admissions
6. Mean / median LOS
7. ISS mean/median for inpatients?
8. Surge strategies? (admissions to non-traditional units / levels of care, etc.)
9. Surge discharge performed?
10. Beds from storage / rental?
11. Transfers to other facilities?
12. Hospitalist role during event?
13. Bed czar (if any) role during event?
14. Other issues / comments?
15. Did nurse to patient ratios change significantly inpatient? If so, for how long?
16. How did patient hand-offs occur? Were they any different from the usual hand-offs?

Mental Health
1. What worked well?
2. What did not?
3. Is staff trained is Psychological First Aid (PFA)?
4. What resources were offered?
5. In-house resources utilized?
6. External resources utilized?
7. Number defusings / debriefings / group sessions conducted?
8. Number of employees receiving individual interventions?
9. Issues identified in week following event
10. Long term issues identified
11. How were debriefings/mental health interventions held (e.g., by department?) were they mandatory?

Family Support Center
1. What worked well?
2. What did not?
3. Where established?
4. Staff needed?
5. Resources needed?
6. Management of unidentified patients / reunification?
7. Coordination with community family assistance center (FAC)?
8. Coordination with faith-based entities?
9. How were families notified?

General
1. Issues with volunteers?
2. Issues with media?
    a. What were the instructions to staff regarding speaking to media?
3. Issues with security?
4. Issues with access to facility (family, media, etc.?)
5. Issues with donations?
6. Issues with vendors?
7. Issues with housekeeping staff/resources Issues with transporters
8. Issues with information sharing? (e.g., requests for patient information / HIPAA issues?)
9. Issues with EMS / situational awareness?
10. Evidence collection / chain of evidence issues?
11. Fatality management issues?

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY